CRESCO CHIROPRACTIC CLINIC P.C.

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Motor Vehicle Collision History

Dear Patient: We need this information because we care enough to want to know, and your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Patient Information **Acct#**___________________

____

Last Name   First Name   Middle Initial   Nick Name

Work Address____Work Phone#___________________

Emergency Contact Information:____Phone#___________________

Responsible Party

Name of person responsible for payment of this account____

Relationship to patient____Phone#_________________

____

Address   City   State   Zip code

Insurance Information

If you have any insurance information please give it to the staff person assisting you

Collision/Injury History

1. Date of Collision:_________Time of Day:_________Road Condition: ( ) Dry ( ) Wet ( ) Icy
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle?____________________
4. Were you wearing a seat belt ( ) Yes ( ) No If no, go to question #6
5. If yes, were you wearing a lap belt? ( ) Yes ( ) No Lap belt and shoulder harness? ( ) Yes ( ) No
6. Did the airbag(s) deploy? ( ) Yes ( ) No
7. What direction were you headed? ( ) North ( ) South ( ) East ( ) West
   On (name of street and city):____
8. What direction was the other vehicle headed? ( ) North ( ) South ( ) East ( ) West
9. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
   Other combination, please describe:____
10. What was the position of your head during the collision?
    ( ) Straight Ahead ( ) Turned Right ( ) Turned Left ( ) Other
11. Did any part of your body strike/hit anything inside of your vehicle (steering wheel, dashboard, etc.)?
    ( ) Yes ( ) No if yes, please explain____
12. Did any items become displaced in the vehicle (rearview mirror, ashtray, packages, etc.)?
    ( ) Yes ( ) No if yes, please describe____
13. Approximate the speed of your vehicle:______mph Estimated speed of other vehicle:______mph
14. Make/model of your vehicle:____________________ Make/model of other vehicle:________________
15. Were the police notified? ( ) Yes ( ) No **Please provide this office with a copy of the police report.**
16. In your own words please describe the collision:____
    ____
    ____

17. Your Auto Insurance Co.____
Policy No.______________________Claim No.______________________

18. Driver of other vehicle (if any)
Name___________________Insurance Company_______________Policy No.______________

19. Driver of vehicle in which you were injured (if applicable)
Name___________________Insurance Company_______________Policy No.______________

20. Name of your insurance adjustor____________________________________Phone#_______________

21. Have you retained an attorney? ( ) Yes ( ) No if yes, list attorney name and address:______________
____

22. Did you have any physical complaints BEFORE the collision? ( ) Yes ( ) No
If yes, please describe in detail:____
____

23. Please describe how you felt:
a. DURING the collision:____
b. IMMEDIATELY AFTER the collision:____
c. LATER THAT DAY:____
d. THE NEXT DAY:____

24. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long?________________________

25. Where were you taken after the collision?____

26. Have you been treated by another healthcare provider since the collision? ( ) Yes ( ) No
If yes, please list the healthcare provider's name and address:_____________________________
____
What type of treatment did you receive?____
____
Were X-rays or other images (MRI,CT, etc.) taken? ( ) Yes ( ) No

27. Did this collision occur while you were performing your regular job duties? ( ) Yes ( ) No

28. How do you feel now? What is your **number one** problem or the **one area** of greatest pain?
____

29. Please rate the level of this pain on the following scale: **0 is no pain at all, 10 is severe pain** or the worst pain you have ever felt. If your pain varies from day to day please circle two numbers to indicate the range of your pain. **0 1 2 3 4 5 6 7 8 9 10**

30. Since the injury occurred, are your symptoms: ( ) Better ( ) Same ( ) Worse

31. How often do you experience the pain?
___1-2 hours per day ___About half of the day ___Most of the day
___The pain never goes away ___Other, briefly explain____________________________

32. How does the pain affect your daily activites?
___It does not affect my daily activites ___I have had to change how I do things
___I have to stop doing some of my daily activites ___I am unable to perform daily activites

33. What **increases** your pain?____

34. What **decreases** your pain?____

35. Have you ever experienced this problem before? ( ) Yes ( ) No When?______________________

36. Do you have a previous illness/disease which affects your present condition? ( ) Yes ( ) No
If yes, please describe:____

37. List any other complaints currently bother you and rate your pain level for each.
a. ___________________________**0 1 2 3 4 5 6 7 8 9 10**
b. ___________________________**0 1 2 3 4 5 6 7 8 9 10**
c. ___________________________**0 1 2 3 4 5 6 7 8 9 10**
d. ___________________________**0 1 2 3 4 5 6 7 8 9 10**

38. Have you lost time form work as a result of this collision/injury? ( ) Yes ( ) No

a. Type of employment:______________________________

b. Last day worked:______________________________

39. Have you ever been involved in a motor vehicle collision before? ( ) Yes ( ) No

a. If yes, when?______________________________

b. Describe the incident(s):______________________________

c. Were you injured? ( ) Yes ( ) No Please Explain:______________________________

____

40. List all medications you are currently taking (prescribed and over the counter)______________________________

____

____

41. List all surgeries/hospitalizations you have had (with date)______________________________

____

____

If you have experienced any of the following conditions in the **past** mark a "**P**" on the line provided. If you are **currently** experiencing any of the following conditions please mark a "**C**" on the line provided. (please mark all that apply)

___heart attack
___diabetes
___difficulty with urination
___prostate problems
___AIDS
___dizziness
___constipation
___nausea
___ears ringing
___Gout
___knee/hip replacement
___Stroke
___Glaucoma
___Diverticulosis

___Anemia
___ulcers
___loss of memory
___diarrhea
___muscle cramping
___headache
___tuberculosis
___broken bones (specifiy below)
___Arthritis
___fainting spells
___difficulty with bowel movements
___Cancer
___Epilepsy
___sprained ankle ( ) R ( ) L

___chest pain
___general fatigue
___soreness in joints
___Migraine
___Syphilis
___gallbladder problems
___kidney stones
___Asthma
___menstrual cramping
___shortness of breath
___sudden weight loss
___loss of hearing
___bloody stools

Please list any other conditions or specify above conditions here:______________________________

____

____

General Activities (check all that apply)

___sleep on waterbed
___sleep in stomach
___sewing
___exercise ________x/wk
___computer/TV/video game____hrs/day

___needlepoint/knitting
___lift weights______x/wk
___jog/run______x/wk
___use cardio equip.______hrs/wk

___fall asleep in recliner/couch
___use two or more pillows
___reading in bed
___swimming_________hrs/wk

Please add anything else you would like the doctor to know:______________________________

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